November 15, 2000

CR 1281

Ambulance Fee Schedule

Final Questions and Answers

The following Questions and Answers address questions and concerns regarding the implementation of the Ambulance Fee Schedule under the Medicare Program.

PRICING

1. Q: How should the blended payment amount be derived for the new mileage code A0425? It would be a complex requirement to compare and compute a charge for both A0380 and A0390 and find the lower then do this blend. Is a blended payment amount required for the new mileage code (A0425)? If so, how is the historical payment portion of the fee schedule computed since a supplier could have a computed reasonable charge for both A0380 and A0390?

   A: The Program Memorandum (PM) provides the information on how to determine this charge. In the PM it states "To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, develop an average from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. Use that average amount as the reasonable charge for 2001 and update it by the Ambulance Inflation Factor."

2. Q: Will carriers need to calculate the 2001 customary and prevailing charges for the current ambulance codes?

   A: No, the carriers do not need to calculate the 2001 customary and prevailing charges for the current ambulance codes; the carriers must update each supplier's reasonable charge by the 2001 ambulance inflation factor.

3. Q: How will carriers price the new codes, like ALS2 and SCT, which have no current code to be used for crosswalking?

   A: Contractors will use the reasonable charge for the highest level ALS code currently paid for each billing method. That is, use ALS emergency transport with specialized ALS services rendered. This corresponds to old codes A0310, A0330, A0350, and A0370 for billing methods 1, 2, 3, and 4, respectively. See Attachment B of the PM for the crosswalk of old codes to new codes.

4. Q: The zip code of the point of pickup establishes whether or not to apply the rural adjustment. It also determines what fee schedule amount to use in the blended fee computation. Therefore, in a carrier site with multiple pricing localities, it is possible a supplier will have multiple allowances for the same procedure code if his points of pickup span pricing localities. Is this interpretation of the requirements correct?

A: Yes, the zip code of the point of pickup determines the locality for the fee schedule amount and whether a rural adjustment applies to the fee schedule amount. However, the reasonable charge portion of the blended payment amount is based on 2000 reasonable charges, which reasonable charges may have been established in multiple pricing localities in 2000. Therefore, a supplier may receive a different blended rate in 2001 for each of two identical services if the respective points of pickup were located in different pricing localities and the reasonable charges established in such pricing localities were different.

5. Q: You can map a prevailing allowance to a zip code, but you cannot map a customary to a zip code, as it is provider specific. So while the fee schedule for point of pickup is based on zip code, the transition part is based solely on the supplier's customary and prevailing, which could potentially be in another locality.

   A: A supplier's customary charge may have been established in a pricing locality that is different from the pricing locality in which the point of pickup is located. However, since the customary is supplier specific, your supplier file should contain the supplier's customary as well as a prevailing by locality. The customary and prevailing localities will be different than the fee schedule locality. Geographically, you should base the reasonable charge the same way you do currently.

6. Q: Will the zip code file be mapped to MPFSDB localities? If that is the case, here are our concerns: The Florida carrier currently has four prevailing localities. If the zip code file is mapped to the MPFSDB localities, (which for Florida is 3 localities), how is the carrier to map the localities. For the 2001 ambulance fee schedule would Florida then have to combine the prevailing fees for localities 01 and 02 in order to map to MPFSDB locality 99? If so, what would the correct calculation i.e., a weighted average? example: Florida reasonable charge localities = 01, 02, 03, 04 to Florida MPFSDB localities = 03, 04 & 99 (99 representing loc 01 & 02 as 1997)

   A: Yes, the zip code file is mapped to the fee schedule file, which comprises localities that are the same as MPFSDB localities. The reasonable charge localities remain the same; they will be different than the fee schedule locality. The fee schedule and reasonable charge amounts are determined independent of one another, then combined in the blending process.

FILES

7. Q: Is the Locality Code on the new fee schedule the pricing localities currently used on the MPFSDB?

   A: Yes.

8. Q: Will there be quarterly maintenance to both the new Ambulance Fee Schedule and the new Zip Code file?

   A: The fee schedule file will be updated annually; the Zip Code file will be updated quarterly.

9. Q: Assuming there will be maintenance to the new fee schedule or zip codes, will HCFA be supplying files of only updates or complete replacement files?

   A. HCFA will furnish complete replacement files.

10. Q: Will HCFA supply the new Ambulance Fee Schedule to the intermediaries?

    A: Yes. The fee schedule applies for ambulance services for claims processed by the Intermediaries. The intermediaries will need the fee schedule to adjudicate their bills.

ELECTRONIC BILLING

11. Q: Where do suppliers who bill electronically code the zip code?

    A: Electronic billers using the NSF are to report the origin information in record EA1. EA1-06 is used to report the address information. EA1-08 is used to report the city name. EA1-09 is used to report the State code. EA1-10 is used to report the zip code.

    Electronic billers using the X12N 837 (4010) are to report the origin information in loop 2310D (Service Facility Location). NM1 is required. NM101 will have the value '77' (Service Location) and NM102 will have the value "2" (Non-person Entity). The remaining fields are not required. N2 is not required. N3 (Service Facility Location Address) is used to report the address information. N4 (Service Facility Location City/State/Zip) is required. N401 is used to report the city name. N402is used to report the State Code and N403 is used to report the Zip Code.
    This information is found in the PM for Ambulance Fee Schedule.

12. Q: Should suppliers report the origin zip code in the X12 CR1 segment, field CR107? According to the 837 Implementation Guide for the 4010 version, data elements CR107 and CR108 in the CR1 segment are "NOT USED." Won't the implementation guide need to be updated prior to implementation of the X12 837 4010 version?

    A: Yes, this is correct. See above for the fields to use for the 4010 version.

13. Q: Should suppliers using the NSF use GA0-19 for the origin zip code, entering the origin code first and then the five-digit zip? GA0-19 is a 40 position free-form field for "Destination Info". We recommend using EA1-10, Facility Lab/Zip Code, and only report the zip code, not the origin. Many carriers currently require or use the GA0-18 (Origin Info) and GA0-19 fields to process ambulance claims.

    A: Yes we agree with you. See question above for the fields to use for the NSF.

PARTICIPATION PACKAGES AND DISCLOSURE

14. Q: Will carriers be required to send participation packages and fee schedules to ambulance suppliers now that all ambulance services are mandatory assignment?

    A: The disclosure of an ambulance supplier specific notice is not a statutory requirement. Ambulance companies are not required to sign participation agreements. Therefore, carriers will not be required to send participation packages and fee schedules to ambulance suppliers.

15. Q: Are carriers required to send each active individual provider a unique fee schedule demonstrating the 80% portion of their reasonable charge and the 20% portion of the fee schedule? How much information will we be required to give, if any, in a scheduled mailing?

    A: A scheduled mailing is not required. Furnish general notice in the appropriate medium and any specific information only upon request.

16. Q: Will this process change carriers' disclosure process. Currently we don't mandate sending reasonable charge disclosures, it is done as a courtesy to them. When would these new fees have to be published to the providers and do we publish both the fee schedule and the reasonable charge amounts?

    A: As indicated above, individual notices to suppliers are not required. Furnish general notice in the appropriate medium and any specific information only upon request. Provider training and brochures will be available to explain the new fee schedule and the blending of the reasonable charge and the fee.

17. Q: Will the ambulance companies have to sign par agreements or will we handle the claims as assigned, regardless of how they come in?

    A: Ambulance companies are not required to sign participation agreements. You can process these claims in the same manner as you handle clinical diagnostic laboratory claims, which also require mandatory assignment.

MANDATORY ASSIGNMENT

18. Q: Will the mandatory assignment provision for carriers be tied to the implementation of the new Ambulance Fee Schedule, or will it be effective 1/1/01 even if the fee schedule is delayed?

    A: Mandatory assignment will be implemented with the fee schedule regulation.

CODING AND CLAIMS PROCESSING

19. Q: How contractors handle no zip code or an invalid zip code on the claim?

    A: Contractors will establish an edit to verify the format of a valid zip code, i.e., there must be five numerics.

    If a claim is received with no zip code or an obviously invalid zip code (e.g. an entry other than all numeric), it should be returned as unprocessable.

    If a claim is received with nine digits, only the first five digits will be used for processing.

    If the zip code is not on the zip code file, the contractor should check with the US Postal Service (USPS) to verify that the zip code submitted is a valid zip code and to find out the area that the zip code covers. If the zip code cannot be confirmed as a valid USPS zip code, the claim will be returned as unprocessable. If the zip code is a valid new zip code, it will pay as an urban code and determine the GPCI for that area.

20. Q: Mileage guidelines for Tennessee and North Carolina are to deny all loaded in-county mileage as included in the base rate. How will the fee schedule affect this?

    A: Pay claims as submitted, subject to applicable Medicare rules. Under the fee schedule all loaded miles are reimbursable.

21. Q: For multiple ambulance transports: are the claims to be reviewed by the contractors based on the zip code of each leg of the transport or are they to be reviewed by one contractor as they are now? (Ref. MCM 3102E). If based on zip code, will there be a process of how the contractor is to obtain the necessary information of the nearest appropriate facility?

    A: The contractor where the trip began has jurisdiction over the entire transport for the duration of the transition period; in other words, contractors will review the claims the way that they do now. Each leg of a transport should be billed separately, specifying the zip code of the point of pickup for that leg to determine the correct fee schedule amount.

22. Q: Sometimes we have multiple ambulance transports for a covered service but it was not medically necessary for multiple ambulances; will the instructions for partial payment of ambulance services in MCM 5215.2 still apply?

    A: Medicare continues to pay the supplier that submits the claim. The supplier can apportion the payment in accordance with MCM 5215.2. Thus, contractors should continue what they do now.

23. Q: For multiple arrivals, the CR states ".... If BLS and ALS entities respond to a call and the BLS entity furnishes the transport after the ALS assessment was furnished, the BLS entity will bill using

the ALS1 rate." Does this means the BLS entity submits the claim with a BLS code and the ALS1 charge? If so, and if limiting charge applies, won't this be affected? Or should the BLS entity submit the claim with an ALS1 code and charge?

A: Limiting charge does not apply to ambulance services.

Medicare pays for the medically necessary service that was actually provided and pays the ambulance company that provided the transport. That means the BLS entity submits a claim for the ALS assessment service using the ALS1 code. If multiple ambulance transports were involved, MCM 5215.2 would apply.

24. Q: How will the provider/supplier indicate on the claim that there were multiple patients transported at one time? Will there be a modifier requirement?

    A: HCFA will request a modifier or identifier for this circumstance. Until then, handle these claims as you do now.

25. Q: Can we use local codes to crosswalk into the new codes? Currently we use codes Y0031 and Y0041 for our air ambulance mileage. Can we crosswalk them into the new codes A0435 and A0436?

    A: Yes. Carriers are responsible for crosswalking local codes to the appropriate HCPCS but only for air services. All other local codes, if any, should be terminated.

BILLING METHODS

26. Q: Current Method 3 and 4 suppliers will be allowed to bill certain supply codes during the transition (e.g. A0382, A0384, A0392, etc.). Will those codes remain active on the 2001 HCPCs file?

    A: Yes, they will be active through the transition period. Further, Method 3 and 4 billers may bill J codes and codes for EKG testing, if medically necessary. The other method billers may not bill for services and items.

27. Q: Please clarify how we would allow Method 3 & 4 ambulance suppliers to bill both the new codes and the old codes through the transition. Method 1 & 2 ambulance suppliers are restricted to the new codes upon implementation.

    A: Method 3 & 4 billers bill only new codes for the transport and mileage that are crosswalk to old HCPCS codes. They may bill old codes only for items and services furnished as an adjunct to the transport, but only those codes specified, and then only through the transition period. Other method suppliers may not bill for items or services.

28. Q: Payment for rural ground mileage involves payment at the higher rural rate for the first 17 miles and payment at the urban rate for every mile over 17. The current PM indicates there is only one HCPCS code for ground mileage (A0425). Can there be consideration for creation a separate

HCPCS code to report the first 17 miles of rural mileage? There's a concern reimbursing a single code at different payment levels on a single line item will cause confusion.

A: This proposal will be considered and, if adopted, implemented later. In the interim, only one HCPCS code will be available for ground mileage upon implementation of the fee schedule.

29. Q: Ambulance suppliers using Method 4 currently can bill injection J-codes and the EKG codes separately. Will this be allowed under the new guidelines? The only old codes that are specified are A0382, A0384 and A0392-A0999. If they continue to bill for these services, what codes and fee amounts should be used?

    A: Yes, both Method 3 and Method 4 billers may bill J codes and EKG codes, if medically necessary. Payment for those services will be based on the supplier's reasonable charge and subject to the appropriate percent for the transition year.

30. Q: Suppliers currently in Method 1 and 3 do not receive separate payment for mileage. When they begin to submit the new mileage code, should we just give them the 20 percent of the new code fee since the mileage payment was part of the service payment,

    A: Pay 20 percent of the fee schedule amount and nothing for the reasonable charge amount. Use the appropriate percentage amount of the fee schedule for subsequent transition years?

31. Q: If an ambulance supplier uses more than one method to bill a carrier, should this continue with the fee schedule?

    A: A supplier should bill only one method in a carrier's jurisdiction. Carriers should convert all suppliers to one billing method beginning with the implementation of the fee schedule, if it is practical. This can be done immediately if the suppliers agree to switch to one method. All suppliers should be notified that they should choose one billing method between now and when the fee schedule is implemented. Until the fee schedule is implemented suppliers can continue as they bill now.

RRB

32. Q: The instruction to compute a reasonable charge at a provider-specific level and basing pricing on point of pickup significantly complicates the RRB contractor's obligation to maintain comparable payment with the local carriers. Further discussions on this topic are essential to ensure efficient and accurate pricing of RRB claims.

    A: See the next question for a full explanation.

33. Q: Per MCM 4620-4621, carriers are required to provide the intermediaries and other entities i.e., RRB, Medicaid, HIS, UMV with our new year prevailing files. Will there be a clear instruction provided regarding how we will transfer this new fee schedule pricing?

A: Per MCM 4620-4621, carriers are required to provide the intermediaries and other entities, i.e., RRB, Medicaid, HIS, UMV with a tape file of locality prevailing charges for ambulance services. Carriers are not required to run the normal reasonable charge update to create the reasonable charge amount. The carriers must provide the information in the format included in the MCM. Upon request from any or all of these entities, the carrier may--but is not required to—provide additional information. Such information could be provided in another format.

JURISDICTION

34. Q: The recent release of HCFA CR#1199 (MCM Part 3; 1030.5 --1030.8) states that the carrier with jurisdiction of the ground ambulance has jurisdiction of all legs of an ambulance trip. We assume that HCFA will revise this MCM reference as it contradicts this draft change request, in which the jurisdiction for each leg of the ambulance trip is based on point of pick-up for that segment of the transport.

    A: The jurisdiction of the claim is not changing for the transition period (years 1, 2, and 3), so the MCM is accurate.

35. Q: Since jurisdiction is changing to point of pick up, we would like clarification on situations that involve multiple states. For example, a supplier's home station is in PA and that supplier has customary data for codes on file in PA. This same supplier picks up a bene in NJ; therefore, the NJ carrier must now process this claim. If the provider is not previously enrolled with the NJ carrier, should the NJ carrier treat this as a new supplier, and how will the carrier obtain the new supplier's reasonable charge amount?

    A: The jurisdiction will remain the same as it is now during the transition period. Suppliers will bill the contractors that they currently bill and a reasonable charge amount should exist for providers within their current jurisdiction.

MISCELLANEOUS

36. Q: What relief is available under the fee schedule to suppliers whose reasonable charge is capped by State or local law such as in Montana and North Carolina?

    A: None. The Medicare fee schedule, including its transition provisions, is not intended to reflect State or locally imposed price limitations. Moreover, even when the fee schedule is fully implemented, Medicare will pay the lower of the submitted charge or the fee schedule amount. Therefore, a supplier submitting a claim with a charge lower than the fee schedule amount will receive the submitted charge in payment. This result obtains regardless of the reason for submitting a low amount.

37. Q: Can we assume that patient liability and medical necessity still apply?

A: Yes.

38. Q: The emergency code description is "An emergency response", are we to look only at the reason for the call/chief complaint? Example: patient fell

A: An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; impairment to bodily functions; or serious dysfunction to any bodily organ or part. If the reason for the call/chief complaint does not meet these criteria and/or if the service provided does not meet these criteria, then the claim should be developed for medical necessity or denied.

39. Q: What is the National EMS Education and Practice Blueprint for the EMT and can contractors obtain this document? (This source is listed under the description of New Ambulance Services.)

A The National Emergency Medical Services Education and Practice Blueprint is available by fax request to: NHSTA/EMS Division, (202) 366-7721.

40. Q: With the HIPPA changes, is it better to make the changes now or wait until HIPPA? What is the impact to the provider community to make multiple changes?

A: Changes necessary to implement the fee schedule must be implemented timely. Such changes should be consistent with HIPPA requirements if possible, but if the changes necessary for the fee schedule cannot be made HIPPA compliant they should, nonetheless, be implemented.

41. Q: When will Attachment 1 of the HCFA 855 Enrollment application be revised to remove the fields to select billing methods? Will there be a HCFA cover letter in the interim, which explains the Method available?

A: The HCFA 855 will be released soon with the fields to select billing methods removed.

42. Q: For an emergency ambulance service that originates in Canada, Mexico, or coastal waters, what zip code should be reported?

A: Enter the five digit zip code for the point of pickup as "00000" (all zeros). Payment will be made based on the nearest USPS zip code ("nearest" being determined as follows: for land transport from point of pick up to the United States border by road, by water from the point of pick up to the nearest appropriate United States port, by air straight line to the United States border). Until provisions are made for electronic submittal, these claims should be submitted in a hard copy format. The zip code of the point of entry should be provided but in a field other than where the "00000" point of pick up information is provided.